STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. A revised copy of the deficiencies was sent to the facility on 4/17/12	F 000		
F 247 SS=D	483.15(e)(2) RIGHT TO NOTICE BEFORE ROOM/ROOMMATE CHANGE A resident has the right to receive notice before the resident's room or roommate in the facility is changed. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 12 sampled for review and 2 reviewed for notification of room or roommate change. Based on observation, interview, and record review, the facility failed to ensure 1 of the 2 reviewed residents received notice before a change in room or roommate (Resident #17). Findings included: - During an interview on 4/2/12 at 2:47 p.m. MST (Mountain Standard Time), resident #17 reported the facility moved his/her belongings without permission or notice to another room while he/she attended a medical appointment. During an interview on 4/4/12 at 2:51 p.m. MST., Activity/Social Service Staff D reported the facility expected administrative staff to address residents' concerns regarding roommate issues. Activity/Social Service Staff D reported a lack of	F 247		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 247	Continued From page 1	F 247		

awareness that resident #17 moved from his/her room.

Resident #17's 12/30/11 Quarterly MDS (Minimum Data Set) reported intact cogntion.

Observations on 4/4/12 at 3:10 p.m. revealed resident #17 as alert and oriented, sat in his/her bedroom recliner, and recalled the events related to room and roommate changes without difficulty.

During an interview on 4/4/12 at 3:11 p.m. MST, resident #17 reported on 8/21/11, staff moved his/her belongings while he/she attended an appointment in another town. Resident #17 reported he/she recalled discussing a room change with staff prior to 8/21/11 but the resident did not choose a room or new roommate. Resident #17 reported in October 2011, he/she did not receive notification prior to receipt of a new roommate, as well.

Review of resident #17's 8/21/11 nursing notes revealed staff moved resident #17's belongings from one room to another while the resident attended an appointment. Further notes revealed staff notified family but lacked documentation that resident #17 received notification or approved of the room change.

Review of resident #17's clinical record revealed a lack of documentation related to notification of a new roommate in October 2011.

During an interview on 4/4/12 at 3:18 p.m. MST, Activity/Social Service Staff D reported he/she lacked awareness of resident #17's room change in August 2011 or resident #17 receipt of a new

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F 247	Continued From page 2 roommate in October 2011. Activity/Social Service Staff D reported not being on duty on 8/21/11. Activity/Social Service Staff D reported he/she recalled resident #17 stated a wish for a room change some time in August 2011 but lacked awareness of a decision by the resident to change rooms. During an interview on 4/5/12 at 9:19 a.m. MST, Administrative Nursing Staff A reported a lack of awareness of which staff discussed the room change with resident #17 prior to the move in August 2011. Administrative Nursing Staff A confirmed documentation failed to show the resident received a choice of room or roommate either in August 2011 or October 2011. The facility failed to ensure resident #17 received notice before a change in room or roommate.	F 247		
F 279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise	F 279		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 3	F 279		

be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).

This REQUIREMENT is not met as evidenced by:
The facility reported a census of 25 residents with 12 sampled for review.

Based on observation, interview, and record review, the facility failed to use the results of an assessment to develop a comprehensive care plan that included measurable objectives and timetables to meet 1 of the 12 sampled resident's needs identified in the comprehensive assessment. (#17)

Findings included:

- The signed Physician Orders dated 3/1/2012 for resident #17 included diagnoses of adult failure to thrive, dehydration, hypothyroidism, vitamin B deficiency, vitamin D deficiency, hypopotassemia, atypical depressive disorder, tobacco use disorder, Alzheimer's disease, Parkinson's disease, essential hypertension, cerebral aneurysm nonruptured, chronic airway obstruction, dyspepsia, constipation, neurogenic bladder, osteoarthrosis, insomnia, edema, history of venous thrombosis and embolism, and long term use of anticoagulants.

The 9/29/2011 Annual MDS (minimum data set) assessment for resident #17 indicated the resident required supervision for transfers. Resident #17 sustained no falls since admission

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 4	F 279		

or since the prior assessment.

The 12/30/2011 Quarterly MDS (minimum data set) assessment for resident #17 identified the resident as cognitively intact with unsteady balance and required limited assistance of one staff for bed mobility, transfers, and ambulation. Resident #17 sustained no falls since admission or since the prior assessment.

Resident #17's 9/30/2011 CAAs (care area assessment) summary for falls indicated he/she had a history of falls and remained at risk for falls.

Record review of resident #17's fall risk assessment completed on 12/30/2011 revealed a score of "10" indicating the resident had a high fall risk.

Record review of resident #17's fall risk assessment completed on 4/3/2012 revealed a score of "18" indicating the resident remained a high fall risk.

Resident #17's 4/3/2012 nursing care plan indicated the resident used a front wheeled walker with supervision in his/her room and used a wheel chair for long distances. The care plan lacked identification of goals or interventions related to fall prevention for resident #17.

Record review of nurse's notes for 3/12/2012 at 8:55 p.m. MST (Mountain Standard Time) indicated resident #17 attempted to get out of bed without assistance and fell. The resident sustained a laceration to his/her left eyebrow and received treatment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 279	Continued From page 5 During an observation on 4/4/2012 at 8:50 a.m. MST, direct care staff K and L assisted resident #17 out of bed and to the bathroom. Resident #17 used his/her four- wheeled walker, took short steps, and shuffled the left foot on the floor. During an interview on 4/5/2012 at 10:00 a.m. MST, administrative nursing staff C verified that resident #17 had a high fall risk and the care plan lacked interventions to prevent falls. The 2/21/2008 fall policy and procedure indicated that "all residents admitted to this facility had a risk for falls due to age, diagnoses, medications, and changes in environment. Staff should complete a fall risk assessment and develop a plan of care for the residents." The facility failed to use the results of an assessment to develop a comprehensive care plan that included measurable objectives and timetables to meet the resident's needs identified in the comprehensive assessment for resident #17 related to falls.	F 279		
F 280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 6 for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 12 residents sampled for review. Based on observation, interview and record review, the facility failed to evaluate and revise 2 of the 12 sampled resident's care plan. The facility failed to review/revise resident #9's care plan after he/she experienced a severe weight loss of 6.6% over a one month period and an 8.2% weight loss over a 3 month period. The facility failed to implement interventions to address the weight loss and prevent additional weight loss. The facility also failed to review/revise resident #15's care plan after placement of an indwelling urinary catheter. Findings included: - The signed Physician Orders dated 3/1/2012 for resident #9 included diagnoses of diabetes mellitus, vascular dementia, frontal lobe syndrome, Alzheimer's disease, constipation, osteoarthrosis, arthropathy, pain, edema, and urine retention.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 280	Continued From page 7	F 280		

The 12/25/2011 Quarterly MDS (minimum data set) assessment for resident #9 identified the resident as rarely or never understood. Resident #9's functional status revealed a total dependence on the assistance of one for oral hygiene and eating. Resident #9 tended to hold food in his/her mouth, did not have a reported weight loss, consumed a therapeutic diet, and had mouth pain or difficulty with chewing.

Resident #9's 6/25/2011 CAAs (care area assessment) summary for nutritional status indicated he/she needed soft foods and assistance with meals.

Resident #9's 4/4/2012 nursing care plan indicated he/she needed to have weight monitored, may need to have a reduced calorie diet, and had a goal of no significant weight gain. Resident #9's care plan also included the weights of 149.5 pounds on 1/8/2012, 145.5 pounds on 2/19/2012, and 137 pounds as the current weight. The care plan lacked specific goals or interventions related to the resident's weight gain or loss. The care plan mentioned a reduced calorie diet, however, did not include specific goals or interventions to achieve these goals.

Record review of the weekly weights:
o 12/27/2011 weight 147 pounds
o 2/26/2012 weight 144.5 pounds
o 3/25/2012 weight 135 pounds
From 2/26/2012 to 3/25/2012 resident #9 sustained a 9.5 pound (6.6%) weight loss in 1 month.
From 12/27/2011 to 3/25/2012 resident #9 sustained a 12 pound (8.2%) weight loss in 3 months.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 280	Continued From page 8 During an observation on 4/4/2012 at 10:00 a.m. MST (Mountain Standard Time), resident #9 received assistance with eating breakfast, took small bites of egg, chewed each bite for several minutes, and required encouragement to continue eating. During an observation on 4/4/2012 at 12:00 p.m. MST, resident #9 received assistance with eating lunch, took small bites of turkey with gravy, mashed potatoes and spinach, chewed each bite for several minutes and required encouragement to continue eating. During an interview on 4/4/2012 at 5:15 p.m. MST, administrative nursing staff A verified resident #9 had weight loss and staff failed to implement interventions related to the weight loss. During an interview on 4/4/2012 at 3:15 p.m. MST (Mountain Standard Time), dietary staff H verified he/she completed the nutritional portion of resident #9's care plan and that portion did not reflect the resident's current condition and did not contain the interventions needed to manage the weight loss. The facility failed to revise and update resident #9's care plan when the resident experienced a severe weight loss of 6.6% over a one month period and an 8.2% weight loss over a 3 month period. The facility failed to implement interventions to address the weight loss and prevent additional weight loss.	F 280		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 9	F 280		

- Resident #15's 2/29/12 physician's orders included diagnoses of acute gastroenteritis, hypokalemia, hypomagnesia, congestive heart failure exacerbation, cerebrovascular accident with left face/arm/leg paralysis, renal insufficiency, restless leg syndrome, atrial fibrillation, controlled type 2 diabetes mellitus, peripheral vascular disease, lumbar spinal stenosis, hypertension, and degenerative knee arthritis. The 3/27/12 physician's orders included an order to place an indwelling urinary catheter.

Resident #15's 1/22/12 Quarterly MDS (Minimum Data Set) Assessment reported moderately impaired cognition, no urinary appliance, and frequently incontinent of urine.

Resident #15's current care plan, dated 9/28/11, included no goals or individualized interventions related to use of an indwelling bladder catheter.

Resident #15's 3/27/12 nursing notes reported licensed staff placed an indwelling urinary catheter using aseptic technique.

Review of resident #15's clinical record revealed no evidence staff reviewed/revised the care plan after staff placed an indwelling bladder catheter on 3/27/12.

Observations on 4/4/12 at 6:35 a.m. MST (Mountain Standard Time) revealed Direct Care Staff Q propelled resident #15 in a wheelchair with an indwelling urinary catheter covered under the resident's wheelchair seat.

During an interview on 4/5/12 at 8:15 a.m. MST,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 280	Continued From page 10 Administrative Nursing Staff C confirmed staff failed to update resident #15's care plan after placement of an indwelling urinary catheter. The facility failed to review/revise resident #15's care plan after placement of an indwelling urinary catheter.	F 280		
F 315 SS=D	483.25(d) NO CATHETER, PREVENT UTI, RESTORE BLADDER Based on the resident's comprehensive assessment, the facility must ensure that a resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary; and a resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 12 sampled for review. Three sampled residents utilized indwelling foley catheters. Based on observation, interview and record review, the facility failed to ensure 1 of 3 sampled residents had valid medical justification for the use of an indwelling catheter (#18). Findings included: - Resident #18's 3/9/12 physicians order sheet listed diagnosis of chronic ischemic heart disease, chronic pulmonary heart disease,	F 315		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 315	Continued From page 11	F 315		

acquired hypothyroidism, vitamin D deficiency iron deficiency anemias, rhythmic disorder, other extrapyramidal diseases and abnormal movement disorders, congestive heart failure, esophagitis, urinary frequency, long-term use of anticoagulants, insomnia, calculus of kidney, and osteoarthrosis.

The Admission (MDS) minimal Data Set on 11/23/11 and the Quarterly MDS on 1/3/12 assessments for resident #18 indicated the resident had moderately impaired cognition, an indwelling catheter, and no toileting program.

The 11/23/11 Care Area Assessment (CAA) summary indicated the resident used an indwelling catheter.

Resident #18's Care Plan dated 1/4/12 indicated the resident required staff assist with personal care, assistance with catheter care, instructed staff to record amount of output from the catheter, and monitor fluids.

Review of the clinical record lacked medical justification for the use of the catheter or reevaluation for continued use of the catheter.

On 4/4/12 at 7:40 a.m. MST (mountain standard time) direct care staff N and direct care staff K provided appropriate catheter care for resident #18. Staff N placed the catheter in a pouch on the back of the wheelchair.

During an interview on 4/3/12 at 4:20 p.m. MST, resident #18 indicated he/she had the catheter since being admitted to the facility in November of 2011.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 315	Continued From page 12 During an interview on 4/4/12 at 12:30 p.m. MST, licensed staff B revealed resident #18 had been in and out of the facility several times. He/she had not always had a foley during past visits. He/she reported the family requested to have the foley inserted because the resident had incontinence. On 4/5/12 at 8:40 a.m. MST, license staff C confirmed resident #18's clinical record lacked a physicians order or medical justification for continued use of the indwelling catheter. During an interview on 4/5/12 at 5:20 p.m. MST, administrative staff A confirmed a lack of physician order for catheter use or valid medical justification for the catheter. The facility failed to ensure valid medical justification for the use of an indwelling foley catheter for resident #18.	F 315		
F 323 SS=G	483.25(h) FREE OF ACCIDENT HAZARDS/SUPERVISION/DEVICES The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 with 12 sampled for review, 3 were reviewed for	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 323	Continued From page 13	F 323		

accidents.
Based on observation, interview and record review, the facility failed to ensure each resident received adequate supervision to prevent accidents for 1 of 3 (#17) residents.

The facility also failed to ensure the resident environment remained as free of accident hazards as possible. The facility reported 9 residents as independently mobile and cognitively impaired. This included potentially hazardous chemicals stored in areas accessible to residents and water temperatures in 6 resident rooms and in commons areas that exceeded 120 degree F (Fahrenheit). (#29, #2, #17, #23, #18, and #6).

Findings included:

- The signed Physician Orders dated 3/1/2012 for resident #17 included diagnoses of adult failure to thrive, dehydration, hypothyroidism, vitamin B deficiency, vitamin D deficiency, hypopotassemia, atypical depressive disorder, tobacco use disorder, Alzheimer's disease, Parkinson's disease, essential hypertension, cerebral aneurysm nonruptured, chronic airway obstruction, dyspepsia, constipation, neurogenic bladder, osteoarthrosis, insomnia, edema, history of venous thrombosis and embolism, long term use of anticoagulants.

The 9/29/2011 Annual MDS (minimum data set) assessment for resident #17 identified the resident as cognitively intact and required supervision for transfers. Resident #17 sustained no falls since admission or since the prior assessment.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 14	F 323		

The 12/30/2011 Quarterly MDS assessment for resident #17 identified the resident as cognitively intact with unsteady balance and required limited assistance of one staff member for bed mobility, transfers, and ambulation. Resident #17 sustained no falls since admission or since the prior assessment.

Resident #17's 9/30/2011 CAAs (care area assessment) summary for falls indicated he/she had a history of falls, remained at risk for falls, and the environment needed to remain free from hazards such as oxygen tubing that might get tangled around his/her feet.

Record review of resident 17's fall risk assessment completed on 12/30/2011 revealed a score of "10" indicating the resident had a high fall risk.

Record review of resident 17's fall risk assessment completed on 4/3/2012 revealed a score of "18" indicating the resident remained a high fall risk.

Resident #17's 4/3/2012 nursing care plan indicated the resident used a front wheeled walker with supervision in his/her room and used a wheel chair for long distances. The 4/3/2012 care plan indicated resident #17 refused restorative therapy. Resident #17's 4/3/2012 nursing care plan lacked revision to include resident's current need of limited assistance with mobility based on 12/30/2012 Quarterly MDS assessment.

Record review of nurse's notes for 3/12/2012 at 8:55 p.m. MST (Mountain Standard Time)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 15	F 323		

indicated resident #17 attempted to get out of bed without assistance and fell. The resident sustained a laceration to his/her left eyebrow. Staff transported resident #17 to the emergency room on a cart at 9:15 p.m. MST (Mountain Standard Time).

Record review of the emergency room documentation for 3/12/2012 indicated the laceration above resident #17's left eyebrow measured 2.5 centimeters and the doctor repaired the laceration using Dermabond adhesive.

During an observation on 4/4/2012 at 8:50 a.m. MST (Mountain Standard Time), direct care staff K and L assisted resident #17 out of bed and to the bathroom. Resident #17 used his/her four-wheeled walker, took short steps, and shuffled the left foot on the floor.

During an interview on 4/5/2012 at 7:45 a.m. MST, resident #17 recalled he/she slipped off the edge of his/her bed and hit his/her head on the bedside drawer last month.

During an interview on 4/4/2012 at 2:10 p.m. MST, direct care staff N verified staff reminded resident #17 to use the call light to get assistance in order to prevent falls and staff had not used any other interventions to prevent falls for resident #17.

During an interview on 4/5/2012 at 10:00 a.m. MST, administrative nursing staff C verified that resident #17 had a high fall risk and the care plan lacked interventions to prevent falls.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 16 During an interview on 4/4/2012 at 5:15 p.m. MST, administrative nursing staff A indicated that staff should evaluate each fall and initiate interventions to prevent future falls. The 2/21/2008 fall policy and procedure indicated that all residents admitted to this facility had a risk for falls due to age, diagnoses, medications, and changes in environment. In the event that a fall occurred, staff should implement the necessary changes to the resident's plan of care immediately. The facility failed to assess and put an effective plan in place to prevent falls for this resident, who the facility identified as a high fall risk. This resident sustained a fall with a laceration which required treatment at the emergency room. - Observations on 4/2/12 at 10:30 a.m. MST (Mountain Standard Time) revealed two 12 ounce cans of Lysol disinfectant spray with a warning label of "keep out of reach of children" and "eye irritant" and a 13 ounce spray bottle of 3M non-acid disinfectant bathroom cleaner with a warning label of "may cause eye, skin, nose, and throat irritation" in the unlocked south hall shower room. During an interview on 4/2/12 at 10:45 a.m. MST, Direct Care Staff R reported the shower room usually remained locked and confirmed staff failed to keep the potentially hazardous chemicals in the shower room out of access to residents. Observations on 4/2/12 at 1:00 p.m. MST	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 17 revealed in a mechanical room, unlocked and unattended by staff, with the doorway propped open on the south hallway with the following chemicals found within easy reach: o a full, 1 quart container of Crew toilet bowl cleaner with a warning label to "keep out of reach of children" o a 1/8 full, 3.17 quart container of Bath Mate acid free cleaner with a warning label of "eye irritant" and "keep out of reach of children" o a full, 17 ounce container of Dymon Grease Gun cleaner with a warning label of "keep out of reach of children," "eye irritant," and "skin irritant" o a full, 17 ounce container of Ozone penetrating lube with a warning label of "harmful vapors" and "keep out of reach of children" o a 1/4 full, 20 ounce container of Powder cleanser double strength with chlorine bleach with a warning label of "eye irritant" and "keep out of reach or children" o a full, 17.7 ounce container of Rose Shineup furniture polish with the warning label of "keep out of reach of children" o a 1/4 full, 48 fluid ounce container of Rug Doctor carpet cleaner with a warning label of "keep out of reach of children" o a full, 23 ounce container of Power foam Bravo with a warning label of "corrosive skin and eye irritant, burns" and "keep out of reach of children" o a full, 19 ounce container of Kaboom Foam cleanser with a warning label of "eye irritant" and "keep out of reach of children" o a 3/4 full, 16.5 ounce container of Fall Misty 11 disinfectant and deodorizer with a warning label to "keep out of reach of children" o a 1/2 full, 18 ounce container of Century water based solvent with a warning label of "keep out of reach of children"	F 323		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 323	Continued From page 18	F 323		

o and a full, 19 ounce container of Glass Betco spray with a warning label of "skin and eye irritant," "harmful if swallowed" and "keep out of reach of children."

During an interview on 4/2/12 at 1:15 p.m. MST, Administrative Nursing Staff B confirmed staff failed to keep residents safe by not securing potentially hazardous chemicals out of residents' reach.

The facility's 4/3/12 "Housekeeping Chemicals and Their Safe Use" policy instructed "all staff [as] responsible to ensure the safe storage of all chemicals in their area and will not allow patients to have access to the bottles of chemicals."

Observations on 4/2/12 between 10:32 a.m. and 10:54 a.m. MST revealed common sink water temperatures (the activity area sink, the shower room sink, the east kitchenette sink, and the south hallway sink) between 121.6 degrees F and 124.5 degrees F. Further observations in residents #29, #2, #17, #23, #18, and #6's rooms between 2:08 p.m. to 3:27 p.m. MST revealed water temperatures between 123.9 degrees F and 128.0 degrees F.

During an interview on 4/4/12 at 1:37 p.m., Housekeeping/Maintenance/Laundry Staff S reported maintenance staff randomly checked resident rooms and common sinks water temperatures weekly with a dial thermometer. Staff S reported a lack of awareness of how to calibrate the dial thermometer.

During a tour and an interview on 4/4/12 at 2:21 p.m., Housekeeping/Maintenance/Laundry Staff S

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 323	Continued From page 19	F 323		

checked water temperatures between two thermometers in the facility and noted one thermometer with a blue sleeve reached 104.0 degrees F and the other with a red sleeve reached 112.0 degrees F. Staff S stated he/she usually used the lower reading dial thermometer with a blue sleeve for all random common and resident room water temperature checks.

Review of the facility's weekly random water temperature checks revealed between 2/1/12 and 3/29/12 that common sinks and random room water temperatures reached between 111.0 degrees F and 118.0 degrees F.

During an interview on 4/5/12 at 11:00 p.m. MST, Housekeeping/Maintenance/Laundry Staff S reported he/she checked resident 29's water temperature which reached 124.0 degrees F with the red sleeved, dial thermometer.

During an interview on 4/5/12 at 8:57 a.m. MST, Housekeeping/Maintenance/Laundry Staff S reported he/she recalibrated the dial thermometer and noted the activity area water temperature reached 124.0 degrees minutes prior to the interview. Staff S confirmed the facility failed to keep water temperatures at a safe range below 120 degrees F.

The facility failed to ensure the residents' environment remained free of accident hazards related to safe water temperatures in residents #29, #2, #17, #23, #18, and #6's rooms and common areas and for 9 cognitively impaired, independently mobile residents when staff stored potentially hazardous chemical products in areas accessible to the residents

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325 SS=G	483.25(i) MAINTAIN NUTRITION STATUS UNLESS UNAVOIDABLE Based on a resident's comprehensive assessment, the facility must ensure that a resident - (1) Maintains acceptable parameters of nutritional status, such as body weight and protein levels, unless the resident's clinical condition demonstrates that this is not possible; and (2) Receives a therapeutic diet when there is a nutritional problem. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 12 residents sampled for review including one resident with nutritional concerns. Based on observation, interview and record review, the facility failed to ensure that one sampled resident maintained acceptable parameters of nutritional status. Resident #9 experienced a severe weight loss of 6.6% over a one month period and an 8.2% weight loss over a 3 month period. The facility failed to assess and implement interventions to address the weight loss. Findings included: - The signed Physician Orders dated 3/1/2012 for resident #9 included diagnoses of diabetes mellitus, vascular dementia, frontal lobe syndrome, Alzheimer's disease, constipation, osteoarthrosis, arthropathy, pain, edema, and	F 325		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 21	F 325		

urine retention.

The 12/25/2011 Quarterly MDS (minimum data set) assessment for resident #9 identified the resident as rarely or never understood. Resident #9's functional status revealed a total dependence on the assistance of one for oral hygiene and eating. Resident #9 tended to hold food in his/her mouth, did not have a reported weight loss, consumed a therapeutic diet, and had mouth pain or difficulty with chewing. Resident #9's height measured 59 inches.

Resident #9's 6/25/2011 CAAs (care area assessment) summary for nutritional status indicated he/she needed soft foods and assistance with meals.

Resident #9's 4/4/2012 nursing care plan indicated he/she needed to have weight monitored, may need to have a reduced calorie diet, and had a goal of no significant weight gain. Resident #9's care plan also included the weights of 149.5 pounds on 1/8/2012, 145.5 pounds on 2/19/2012, and 137 pounds as the current weight. The care plan lacked specific goals or interventions related to the resident's weight gain or loss. The care plan mentioned a reduced calorie diet, however, did not include specific goals or interventions to achieve these goals.

Dietary Consultant J ' s progress notes on 1/19/12 revealed resident #9 had a " significant weight loss of 4 pounds in one week " and recommended " no change in [the resident ' s] diet. The 3//15/2012 progress note also documented the resident had weight loss.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 22	F 325		

A nutritional assessment completed by dietary staff H on 3/26/12 identified a weight loss of 12 pounds in 90 days with a current weight of 135 pound. The assessment also stated the resident had a food intake of 52% of meals and received snacks twice daily.

Record review of Physician orders dated 3/1/2012 revealed resident #9 had no nutritional supplements ordered and consumed an 1800 calorie diabetic diet. The Physician orders lacked evidence of orders for a planned weight loss. Record review of resident #9 ' s laboratory tests indicated the resident had a total protein of 6.5 grams per deciliter on 10/4/11 (normal range 6.4-8.2 g/dL) and an albumin level of 3.4 g/dL (normal 3.4-5.0 g/dL).

Resident #9 ' s weekly weight record revealed the following weights:

* 12/25/11 147 lbs.(pounds)
* 01/01/12 146.5 lbs.
* 01/08/12 149.5 lbs.
* 01/15/12 145.5 lbs.
* 01/22/12 147 lbs.
* 01/29/12 146 lbs.
* 02/05/12 150 lbs.
* 02/12/12 146 lbs.
* 02/19/12 145.5 lbs.
* 02/26/12 144.5 lbs.
* 03/04/12 141.5 lbs.
* 03/11/12 138 lbs.
* 03/18/12 138 lbs.
* 03/25/12 135 lbs.

Calculation of resident #9 ' s weight loss revealed a 1 month weight loss from 02/26/12 (144.5 lbs.)

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 23	F 325		

to 03/25/12 (135 lbs.) of 9.5 lbs., a 6.6% weight loss. The resident had a 3 month weight loss from 12/27/11 to 3/25/12 of 12 lbs, an 8.2% weight loss.

During an observation on 4/4/2012 at 10:00 a.m. MST (Mountain Standard Time), resident #9 received assistance with eating breakfast, took small bites of egg, chewed each bite for several minutes, and required encouragement to continue eating without offering substitutes.

During an observation on 4/4/2012 at 12:00 p.m. MST, resident #9 received assistance with eating lunch, took small bites of turkey with gravy, mashed potatoes and spinach, chewed each bite for several minutes and required encouragement to continue eating without offering substitutes.
During an interview on 4/4/2012 at 5:15 p.m. MST, administrative nursing staff A verified resident #9 had weight loss and staff failed to implement interventions related to the weight loss.

During an interview on 4/4/2012 at 3:15 p.m. MST, dietary staff H verified he/she completed resident #9's Nutritional Assessments and did not realize the significance of the weight loss. Dietary staff reported he/she saw resident #9's weekly weights, but only calculated the percentage of weight loss quarterly. Dietary staff H further verified he/she completed the nutritional portion of resident #9's care plan and that portion did not reflect the resident's current condition and did not contain the interventions to address the resident's weight loss.

During an interview on 4/5/2012 at 2:10 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 325	Continued From page 24 MST, consultant staff J verified that he/she came monthly, reviewed resident #9's medical record, and consulted with staff regarding the resident's nutritional condition and needs. Dietary staff J further verified that during his/her review of resident #9's information on 3/15/2012, he/she may not have considered that resident #9 had a significant weight loss considering the resident remained above his/her ideal body weight of 98 pounds. Based on the weights recorded from 2/5/2012 to 3/25/2012 which indicated a steady weight loss, resident #9 should have received a supplement to support his/her nutritional needs. The facility failed to ensure that one sampled resident maintained acceptable parameters of nutritional status. Resident #9 experienced a severe weight loss of 6.6% over a one month period and an 8.2% weight loss over a 3 month period. The facility failed to implement effective interventions to address resident #9 ' s weight loss and the resident continued to lose weight. The clinical record lacked evidence to show this weight loss was unavoidable.	F 325		
F 329 SS=E	483.25(l) DRUG REGIMEN IS FREE FROM UNNECESSARY DRUGS Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used in excessive dose (including duplicate therapy); or for excessive duration; or without adequate monitoring; or without adequate indications for its use; or in the presence of adverse consequences which indicate the dose should be reduced or discontinued; or any combinations of the reasons above. Based on a comprehensive assessment of a	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 25 resident, the facility must ensure that residents who have not used antipsychotic drugs are not given these drugs unless antipsychotic drug therapy is necessary to treat a specific condition as diagnosed and documented in the clinical record; and residents who use antipsychotic drugs receive gradual dose reductions, and behavioral interventions, unless clinically contraindicated, in an effort to discontinue these drugs. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 10 residents sampled for unnecessary medication review. Based on observation, interview, and record review, the facility failed to ensure that 10 of the 10 residents sampled for unnecessary drugs (drugs used without adequate monitoring) when the facility failed to monitor for potential side effects and adverse reactions as related to black box warnings (#15, 27, 10, 20, 12, 16, 26, 18, 2, and 17). - Resident #15's 2/29/12 physician's orders included diagnoses of acute gastroenteritis, hypokalemia, hypomagnesia, congestive heart failure exacerbation, cerebrovascular accident with left face/arm/leg paralysis, renal insufficiency, restless leg syndrome, atrial fibrillation, controlled type 2 diabetes mellitus, peripheral vascular disease, lumbar spinal	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 26	F 329		

stenosis, hypertension, and degenerative knee arthritis. The 2/29/12 physician's orders included an order for Seroquel (an antipsychotic medication) 25 mg (milligrams) by mouth every evening for agitation.

Resident #15's 1/22/12 Quarterly MDS (Minimum Data Set) Assessment reported moderately impaired cognition, mild depression, and received antipsychotic and antidepressant medications.

Resident #15's 9/28/11 care plan failed to mention the resident received Seroquel or Seroquel's Black Box Warning.

According to blackboxrx.com, Seroquel (Quetiapine) increased mortality in elderly patients with dementia related psychosis greater than placebo.

Observations on 4/3/12 1:14 p.m. MST (Mountain Standard Time) revealed resident #15 sat in a bedroom recliner with a call light within reach, covered by a blanket, and his/her legs remained elevated on the recliner foot rest.

During an interview on 4/5/12 at 8:31 a.m. MST, Administrative Nursing Staff C confirmed the facility failed to add Black Box Warnings to the residents' care plans.

The facility failed to ensure resident #15 did not receive unnecessary drugs (drugs used without adequate monitoring) when the facility failed to monitor for potential side effects and adverse reactions as related to black box warnings for Seroquel.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 27 - Resident #27's 3/9/12 physician's orders included diagnoses of congestive heart failure, atrial fibrillation, hypothyroidism, hypercholesterolemia, hypopotassemia, dementia without behavioral disturbances, depressive disorder, glaucoma, hypertension, coronary arteriosclerosis, osteoarthrosis of pelvic and thigh region, and a pacemaker. The 3/9/12 physician's orders renewed orders for Amiodorone (a heart medication) 200 mg (milligrams) by mouth daily and Acetaminophen (a pain and fever medication) 500 mg by mouth at breakfast and 650 mg by mouth every four hours as needed for pain. Resident #27's 3/23/12 Annual MDS I(Minimum Data Set) Assessment reported severely impaired cognition and the resident did not receive a special category of medications. Resident #27's 4/3/12 lacked mention of black box warnings for Amiodorone or Acetaminophen. According to blackboxrx.com, Amiodorone (Cordarone) posed "major management problems that could be life-threatening in a population at risk of sudden death, so that every effort should be made to utilize alternative agents first and liver injury is common with Cordarone, but is usually mild and evidenced only by abnormal liver enzymes. Overt liver disease can occur, however, and has been fatal in a few cases." According to blackboxrx.com, Acetaminophen held the "potential for severe liver injury and a warning highlighting the potential for allergic reactions (e.g., swelling of the face, mouth, and	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 28	F 329		

throat, difficulty breathing, itching, or rash) [were] being added to the label of all prescription drug products that contain acetaminophen."

Observations on 4/4/12 11:05 a.m. MST (Mountain Standard Time) revealed resident #27 ambulated independently in his/her room with a steady gait.

During an interview on 4/4/12 at 3:23 p.m. MST, Licensed Nursing Staff B confirmed resident #27's care plan lacked mention or the content of the black box warning for Amiodorone or Acetaminophen.

The facility failed to ensure resident #27 did not receive unnecessary drugs (drugs used without adequate monitoring) when the facility failed to monitor for potential side effects and adverse reactions as related to black box warnings for Amiodorone and Acetaminophen.

- Resident #10's physicians order sheet listed the following diagnoses of dominant side hemiplegia, hypertension, depressive disorder, aphasia, dysphagia, obesity, anxiety state, convulsions and hypothyroidism and constipation. The physician order sheet also included an order for Fentanyl patch 50 mcg (micrograms) to be changed every 3 days.

Resident #10's 2/4/12 Quarterly MDS Assessment indicated the resident had a moderately impaired cognitive status and received an antidepressant medication during the assessment period.

Resident #10's 2/2/12 Care Plan failed to mention

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 29	F 329		

any monitoring for side effects or adverse reactions from the use of medications which had black box warnings.

According to blackboxrx.com the following medication contained black box warnings: Fentanyl: "This product contains a high concentration of a potent Schedule 2 opioid agonist, fentanyl. Schedule 2 opioid substances have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression."

Review of resident #10's monthly Medication Regimen Review for the past year revealed a lack of information related to black box warnings.

On 4/4/12 at 6:35 a.m. (MST) mountain standard time, direct care staff L and R assisted resident #10 with morning cares. The resident had no signs of depression or inappropriate behaviors during cares.

An interview with licensed staff C on 4/4/12 at 8:30 a.m. MST confirmed that monitoring for medications with black box warnings had not been included in the residents' nursing care plans.

The facility failed to provide adequate monitoring for potential side effects and adverse reactions to medications with BBW. Resident #10 received a Fentanyl Patch which had a BBW.

- Resident #20's 2/8/12 physician order sheet listed diagnoses of depression, nonpsychotic mental disorder, Parkinson's disease, hypertension, hypoactive sexual desire disorder,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 30	F 329		

coronary atherosclerosis, congestive heart failure, and osteoarthrosis. The physician's order sheet also had an order for Seroquel 25 mg (milligram) at hour of sleep.

Resident #20's 12/26/11 quarterly MDS (Minimum Data Set) assessment revealed the resident had intact cognition, no inappropriate behaviors, and received antidepressant medications.

The resident's 12/21/11 nursing care plan had information related to the resident's diagnosis of depression, however, the care plan lacked any information related to the resident's use of Seroquel which had a BBW (Black Box Warning).

According to blackboxrx.com, Seroquel contained this BBW, "Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo" and "close observation for suicidal thinking or unusual changes in behavior."

During an observation on 4/4/12 at 11:30 a.m. MST (Mountain Standard Time), resident #20 sat at the dining room table after eating a meal. The resident had no inappropriate behaviors during the meal.

An interview on 4/4/12 at 2:34pm MST with licensed staff C revealed resident #20's nursing care plan did not include information related to medications that had BBWs.

During an interview on 4/4/12 at 3:30 p.m. MST, administrative nurse A confirmed the facility currently did not include information regarding BBWs in the residents' nursing care plans.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 31	F 329		

The facility failed to ensure resident #20 did not receive unnecessary drugs when staff failed to adequately monitor for potential side effects and adverse reactions as related to a BBW for Seroquel.

- Resident #12's physicians order sheet listed the following diagnoses of hypopotaassemia, depression, parkinson ' s disease, macular degeneration, hypertension, coronary atherosclerosis, dyspepsia, vertigo, chronic airway obstruction, and osteoarthritis. The physicians order sheet also included an order for Toprol (a high blood pressure medication) 25 mg (milligrams) by mouth twice a day.

Resident # 12's 7/21/11 Annual MDS (Minimum Data Set) Assessment and the 10/20/11 Quarterly MDS indicated severely impaired cognition.

Resident # 12's Care Plan failed to mention any monitoring for side effects or adverse reactions from the use of medications which had black box warnings.

According to blackboxrx.com, the following medication contained a black box warning: Toprol: "Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with coronary artery disease) but gradually tapered over 1-2 weeks to avoid acute tachycardia, hypertension, and/or ischemia."

Review of resident # 12's monthly Medication Regimen Review for the past year revealed a lack of information related to black box warnings.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 32 On 4/4/12 at 8:15 a.m. MST direct care staff L and R assisted resident # 12 to restroom with a steady gait noted. An interview with licensed staff C on 4/4/12 at 8:30 a.m. MST confirmed that monitoring for medications with black box warnings had not been included in the residents' nursing care plans. During an interview on 4/5/12 at 10:55 a.m. MST consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with BBWs, but had not incorporated the information into the nursing care plans. The facility failed to ensure resident # 12 did not receive unnecessary drugs when staff failed to adequately monitor for potential side effects and adverse reactions as related to Black Box Warnings for Toprol. - Resident #16's 3/8/12 physician order sheet included diagnoses of anxiety state, hypothyroidism, hypopotassemia, dementia, depressive disorder, macular degeneration, hypertension, congestive heart failure, dyspepsia, cerebral atherosclerosis, osteoarthosis, and insomnia. The physician order sheet included an order for Seroquel 25 mg (milligrams) at hour of sleep. Resident #16's 1/29/12 quarterly MDS (minimum data set) assessment revealed the resident had intact cognition and received antipsychotic and	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 33 antidepressant medications. Resident #16's current nursing care plan included information related to anxiety and depression, however, lacked any information regarding potential side effects and adverse reactions related to the use of Seroquel which had a BBW (Black Box Warning). According to blackboxrx.com, Seroquel contained this BBW, "Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo" and "close observation for suicidal thinking or unusual changes in behavior," During an observation on 4/3/12 at 3:00 p.m. MST (Mountain Standard Time), resident #16 ambulated in the hallway with a steady gait and did not exhibit any signs of depression or inappropriate behaviors. An interview on 4/4/12 at 2:34 p.m. MST with licensed staff C revealed resident #16's nursing care plan did not include information related to medications that had BBWs. During an interview on 4/4/12 at 3:30 p.m. MST, administrative nurse A confirmed the facility currently did not include information regarding BBWs in the residents' nursing care plans. The facility failed to ensure resident #16 did not receive unnecessary drugs when staff failed to adequately monitor for potential side effects and adverse reactions as related to a BBW for Seroquel. - The signed Physician Orders dated 2/1/2012	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 34	F 329		

for resident #2 included diagnoses of subendocardial infarction, congestive heart failure, anemia, sleep arousal disorder, depressive disorder, other extrapyramidal diseases and abnormal movement disorders, other specified hemiplegia and hemiparesis affecting unspecified side, tear film insufficiency, essential hypertension, coronary atherosclerosis of unspecified type of vessel, transient cerebral ischemia, late effects of cerebrovascular disease, constipation, hemorrhage of gastrointestinal tract, pain in joint involving multiple sites, general muscle weakness, osteoporosis, dizziness and giddiness, insomnia, weight loss, diarrhea, urinary incontinence, history of diseases of circulatory system not elsewhere classified.

Resident #2's signed Physician Orders dated 2/1/2012 included an order for Tylenol 500 milligrams.

The 2/24/2012 Quarterly MDS (minimum data set) assessment for resident #2 identified him/her with severely impaired cognition, no reported behaviors, no reported falls, and reported mild pain received pain medication.

Resident #2's 4/3/2012 nursing care plan lacked direction to staff related to the use of Tylenol which had a BBW (Black Box Warning).

According to blackboxrx.com, Acetaminophen (Tylenol) had the potential for causing severe liver injury and had the potential for causing allergic reactions such as: swelling of the face, mouth, and throat, difficulty breathing, itching or a rash.

During an observation on 4/3/2012 at 4:50 p.m.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 35	F 329		

MST, resident #2 stood in his/her room, in front of his/her wheel chair, alert, sorting papers, without signs of pain or distress noted.

During an interview on 4/4/2012 at 5:15 p.m. MST (Mountain Standard Time), administrative nursing staff A verified that resident #2's care plan lacked information related to the Black Box Warning for Tylenol.

The facility failed to ensure resident #2 did not receive unnecessary drugs (drugs used without adequate monitoring) when the facility failed to monitor for potential side effects and adverse reactions as related to BBWs for Tylenol.

- The signed Physician Orders dated 3/1/2012 for resident #17 included diagnoses of adult failure to thrive, dehydration, hypothyroidism, vitamin B deficiency, vitamin D deficiency, hypopotassemia, atypical depressive disorder, tobacco use disorder, Alzheimer's disease, Parkinson's disease, essential hypertension, cerebral aneurysm nonruptured, chronic airway obstruction, dyspepsia, constipation, neurogenic bladder, osteoarthrosis, insomnia, edema, history of venous thrombosis and embolism, long term use of anticoagulants.

Resident #2 ' s signed Physician Orders dated 2/1/2012 included orders for Fluoxetine 20 milligrams, Tylenol 500 milligrams, Remeron 15milligrams, and Coumadin 2 milligrams.

The 12/30/2011 Quarterly MDS (minimum data set) assessment for resident #17 identified the resident as cognitively intact with no behaviors noted, urine incontinence, occasional pain and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 36 received pain medication and an antidepressant. Resident #17's 4/3/2012 nursing care plan lacked direction to staff related to the use of Fluoxetine, Tylenol, Remeron, and Coumadin which all had BBWs (Black Box Warnings). According to blackboxrx.com, the following medications contained BBWs: o Fluoxetine: patients started on Fluoxetine had the potential for clinical worsening, suicidality, or unusual changes in behavior. o Tylenol: Acetaminophen (Tylenol) had the potential for causing severe liver injury and had the potential for causing allergic reactions such as: swelling of the face, mouth, and throat, difficulty breathing, itching or a rash. o Remeron: patients started on Remeron (Mirtazapine), had the potential for clinical worsening, suicidality, or unusual changes in behavior. o Coumadin: Coumadin (Warfarin) had the potential to cause major or fatal bleeding at the beginning of therapy and with higher doses resulting in a higher INR (International Normalized Ratio). During an observation on 4/4/2012 at 8:50 a.m. MST (Mountain Standard Time), direct care staff K and L assisted resident #17 out of bed and to the bathroom. Resident #17 had no signs or symptoms of pain or distress noted during transfer and ambulation. Resident remained calm and cooperative with staff members. During an interview on 4/4/2012 at 5:15 p.m. MST (Mountain Standard Time), administrative nursing staff A verified that resident #17 ' s care plan lacked information related to Black Box Warning	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 37 for Fluoxetine, Tylenol, Remeron (Mirtazapine), and Coumadin (Warfarin). The facility failed to ensure resident #17 did not receive unnecessary drugs (drugs used without adequate monitoring) when the facility failed to monitor for potential side effects and adverse reactions as related to BBWs for Fluoxetine, Tylenol, Remeron, and Coumadin. - Resident #26's 3/7/12 physicians order sheet listed diagnosis of adult failure to thrive, anxiety disorder, vitamin D deficiency, coronary atherosclerosis of artery bypass graft, urinary tract infection, osteoarthrosis, epistaxis, urinary incontinence and allergies. Physician order sheet also listed orders for Tylenol, Lasix, Atenolol, and Coumadin. The Quarterly (MDS) Minimal Data Set on 2/21/12 indicated resident #26 had severely impaired cognitive cognition and received antidepressant therapy. Review of resident #26's care plan revealed the care plan lacked direction to staff regarding potential side effects and adverse reaction of medication with BBW (black box warning). According to www.blackboxrx.com the following medication contained black box warnings: Acetaminophen: " In addition, a Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (e.g., swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) are being added to the label of all	F 329		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 38	F 329		

prescription drug products that contain acetaminophen".
Lasix: "This agent is a potent diuretic which, if given in excessive amounts, may lead to profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule must be adjusted to the individual patient ' s needs (see DOSAGE AND ADMINISTRATION)."
Atenolol: "Beta-blocker therapy should not be withdrawn abruptly but gradually tapered to avoid acute tachycardia, hypertension, and/or ischemia".
Coumadin: " May cause major or fatal bleeding."

On 4/4/12 at 7:50 a.m. MST (mountain standard time) direct care staff K and M assisted resident # 26 with activities of daily living. The resident remained calm and cooperative with cares.

During an interview on 4/4/12 at 12:30 p.m. MST administrative nurse B confirmed resident #26's nursing care plan lacked information regarding potential side effects and adverse reactions of black box medications.

The facility failed to provide adequate monitoring for potential side effects and adverse reactions to medications with BBW. Resident # 26 received Lasix, Atenolol, Coumadin and Tylenol which had BBWs.

- Resident #18's 3/9/12 physicians order sheet listed diagnosis of chronic ischemic heart disease, chronic pulmonary heart disease, acquired hypothyroidism, vitamin D deficiency iron deficiency anemias, dysthymic disorder, other extrapyramidal diseases and abnormal

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 39	F 329		

movement disorders, congestive heart failure, esophagitis, urinary frequency, long- term use of anticoagulants, insomnia, calculus of kidney, and osteoarthrosis. The physician order sheet also listed orders for Tylenol, Lasix, Cuprimine, Atenolol, and Coumadin.

The Admission MDS (Minimal Data Set) on 11/23/11 and the Quarterly MDS on 1/3/12 assessments for resident #18 indicated the resident had moderately impaired cognition, no behaviors, and received antidepressants.

Residents #18's care plan on 4/3/12 lacked direction to staff regarding potential side effects and adverse reaction related to acetaminophen, lasix, cuprimine, atenolol and coumadin, which had BBWs (Black Box Warning).

According to www.blackboxrx.com the following medication contained black box warnings:
Acetaminophen: " In addition, a Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (e.g., swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) are being added to the label of all prescription drug products that contain acetaminophen".
Lasix: "This agent is a potent diuretic which, if given in excessive amounts, may lead to profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule must be adjusted to the individual patients needs (see DOSAGE AND ADMINISTRATION)."
Cuprimine: " Physicians planning to use penicillamine should thoroughly familiarize

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 329	Continued From page 40 themselves with its toxicity, special dosage considerations, and therapeutic benefits. penicillamine should never be used casually. Each patient should remain constantly under the close supervision of the physician. Patients should be warned to report promptly any symptoms suggesting toxicity ." Atenolol: "Beta-blocker therapy should not be withdrawn abruptly but gradually tapered to avoid acute tachycardia, hypertension, and/or ischemia." Coumadin: "May cause major or fatal bleeding." Observations of resident # 18 on 4/3/12 at 4:15 p.m. MST (mountain standard time) revealed an alert, cooperative, calm. and oriented resident. During an interview on 4/4/12 at 12:30 p.m. MST licensed staff B confirmed that resident # 18's care plan lacked information related to potential side effects and adverse reactions to medications with BBWs. The facility failed to provide adequate monitoring for potential side effects and adverse reactions to medications with BBWs. Resident #18 received Acetaminophen, Lasix, Cuprimine, Atenolol and Coumadin, which had BBWs.	F 329		
F 334 SS=E	483.25(n) INFLUENZA AND PNEUMOCOCCAL IMMUNIZATIONS The facility must develop policies and procedures that ensure that -- (i) Before offering the influenza immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization;	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 334	Continued From page 41 (ii) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated or the resident has already been immunized during this time period; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicates, at a minimum, the following: (A) That the resident or resident's legal representative was provided education regarding the benefits and potential side effects of influenza immunization; and (B) That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal. The facility must develop policies and procedures that ensure that -- (i) Before offering the pneumococcal immunization, each resident, or the resident's legal representative receives education regarding the benefits and potential side effects of the immunization; (ii) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated or the resident has already been immunized; (iii) The resident or the resident's legal representative has the opportunity to refuse immunization; and (iv) The resident's medical record includes documentation that indicated, at a minimum, the following: (A) That the resident or resident's legal	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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F 334	Continued From page 42 representative was provided education regarding the benefits and potential side effects of pneumococcal immunization; and (B) That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal. (v) As an alternative, based on an assessment and practitioner recommendation, a second pneumococcal immunization may be given after 5 years following the first pneumococcal immunization, unless medically contraindicated or the resident or the resident's legal representative refuses the second immunization. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents. The sample included 5 residents. Based on interview and record review the facility failed to provide 5 of 5 residents and/or the residents' legal representatives with educational information on influenza, including the benefits and potential side effects of the immunization. (Residents #14, #13, #19, #22, and #4) Findings included: - Review of the information provided by administrative nursing staff C from the clinical records of 5 sampled residents revealed the following information as related to influenza and pneumococcal immunizations.	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

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F 334	Continued From page 43 Resident #14: received the pneumococcal immunization prior to this 12 month review and received the influenza immunization on 10/14/2011. Although the DPOA (durable power of attorney) signed the immunization consent form, the clinical record lacked evidence the resident and/or DPOA received educational information related to the benefits and potential side effects of the vaccine. Resident #13: refused the pneumococcal immunization prior to this 12 month review and received the influenza immunization on 10/14/2011. Although the DPOA (durable power of attorney) signed the immunization consent form, the clinical record lacked evidence the resident and/or DPOA received educational information related to the benefits and potential side effects of the vaccine. Resident #19: received the pneumococcal immunization prior to this 12 month review and received the influenza immunization on 10/14/2011. Although the DPOA (durable power of attorney) signed the immunization consent form, the clinical record lacked evidence the resident and/or DPOA received educational information related to the benefits and potential side effects of the vaccine. Resident #22: received the pneumococcal immunization prior to this 12 month review and received the influenza immunization on 10/14/2011. Although the DPOA (durable power of attorney) signed the immunization consent form, the clinical record lacked evidence the resident and/or DPOA received educational information related to the benefits and potential	F 334		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

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GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 334	Continued From page 44 side effects of the vaccine. Resident #4: received the pneumococcal immunization prior to this 12 month review and received the influenza immunization on 10/14/2011. Although the DPOA (durable power of attorney) signed the immunization consent form, the clinical record lacked evidence the resident and/or DPOA received educational information related to the benefits and potential side effects of the vaccine. During an interview on 4/3/2012 at 4:15 p.m. MST (Mountain Standard Time), administrative nursing staff C verified that neither the residents nor the legal representatives consistently received the immunization education required for both the influenza and pneumococcal immunizations before administering the immunizations. The immunization policy and procedure dated 3/15/2011 indicated each resident who wanted an immunization would receive education about the immunization prior to administration of it and the information needed documented in the resident's medical record. The facility failed to provide 5 of 5 residents and/or the residents' legal representatives with educational information on influenza immunization, including the benefits and potential side effects the immunization. (Residents #14, #13, #19, #22, and #4)	F 334		
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis:	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

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GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 356	Continued From page 45 o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents. Based on observation, interview, and record review, the facility failed to post the following information on a daily basis: the total number and the actual hours worked by staff	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 356	Continued From page 46 categories of the licensed nursing staff of Registered Nurse and Licensed Practical Nurse resident census maintain the posted daily nurse staffing data for a minimum of 18 months. Findings included: - Observations on 4/2/12 at 10:41 a.m. MST (Mountain Standard Time) revealed a dry erase board with nurse staffing information for 4/2/12 between the facility's atrium and the east hallway. Review of the dry erase board revealed nurse staffing data lacked mention of the actual hours worked for 7 of 9 staff listed, the titles of the licensed nursing staff on both of the 12 hour shifts, and the current census. Observations on 4/3/12 at 9:19 a.m. MST revealed the dry erase board with nurse staffing information updated for 4/3/12 day and night shifts but lacked actual hours worked for all staff, the titles of the day and night licensed nurses, and the current census. During an interview on 4/5/12 at 9:12 a.m. MST, Administrative Nursing Staff A reported a lack of awareness of the required nurse staffing data to post such as the total number and the actual hours worked by staff, the categories of the licensed nursing staff of Registered Nurse and Licensed Practical Nurse, the resident census, and to maintain the posted daily nurse staffing data for a minimum of 18 months. Although requested, the facility did not provide records of posted staffing for the past 18 months.	F 356		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 356	Continued From page 47 The facility failed to post on a daily basis the total number and the actual hours worked by staff, the categories of the licensed nursing staff of Registered Nurse and Licensed Practical Nurse, the resident census, and to maintain the posted daily nurse staffing data for a minimum of 18 months.	F 356		
F 363 SS=D	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents. The facility had one kitchen and one resident received a pureed diet. Based on observation, interview, and record review, the facility failed to ensure one resident on a pureed diet received foods that met the nutritional needs of the resident in accordance with the recommended dietary allowances. The facility failed to follow the recipes for pureed foods for one non-sampled resident. Findings included: - Observations on 4/3/12 at 5:06 p.m. MST (Mountain Standard Time) revealed Dietary Staff T placed a 4 ounce scoop of beef stroganoff and	F 363		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

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F 363	Continued From page 48	F 363		

an unmeasured amount of lukewarm beef broth from a can in the blender.

Observations on 4/3/12 at 5:12 p.m. MST revealed Dietary Staff T scooped a small serving bowl of tossed lettuce salad into a clean blender with his/her gloved hand. At 5:13 p.m. MST, Dietary Staff T added another small serving bowl of tossed lettuce salad with his/her gloved hand and an unmeasured amount of cold vegetable juice into the blender.

During an interview on 4/3/12 at 5:35 p.m., Dietary Staff H reported dietary staff did not have a recipe for pureed beef stroganoff or tossed salad. At 5:41 p.m., Dietary Staff H located a recipe for pureed tossed salad. On 4/4/12 at 8:12 a.m., Dietary Staff H presented a pureed recipe for "casserole."

Review of the facility's undated "dysphagia puree (level 1) diet, for casserole" instructed staff to serve "6 oz (ounces)" and add "1 tablespoon of gravy or broth"

Review of the facility's undated recipe for "pureed vegetables and salads" and "tossed salad" indicated the smallest serving as 5 servings. For 5 servings, the recipe indicated to use 1 1/4 quart of salad/prepared such as "tossed or garden", 2 1/2 slices of bread, and 1/2 cup of Italian dressing or milk.

During an interview on 4/4/12 at 4:20 p.m. Dietary Staff H confirmed dietary staff failed to follow the registered dietician approved recipe for beef stroganoff and tossed lettuce salad by:
o failure to use the correct size serving of 6

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 363	Continued From page 49 ounces, not 4 ounces o failure to add bread to the tossed lettuce salad o failure to use Italian dressing or milk instead of vegetable juice in the tossed lettuce salad. During an interview on 4/5/12 at 1:50 p.m. MST, Consultant Staff J confirmed the facility failed to follow the beef stroganoff and tossed lettuce salad recipes as approved by the registered dietician. The facility failed to ensure one resident on a pureed diet received foods that met the nutritional needs of the resident in accordance with the recommended dietary allowances. The facility failed to follow the recipes for pureed foods for one non-sampled resident.	F 363		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with one kitchen and one dining area. Based on observation, interview, and record review, the facility failed to store, prepare,	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

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F 371	Continued From page 50	F 371		

distribute, and serve food under sanitary conditions, which affected all residents including resident #6.

Findings included:

- Observations on 4/2/12 between 11:25 a.m. and 11:31 a.m. MST (Mountain Standard Time) revealed Dietary Staff F touched multiple residents' clothing, wheelchair handles, table tops, and backs of residents' chairs while he/she touched the eating surface of plates of strawberry cake with the thumb of his/her contaminated glove that he/she served to each resident.

Observations on 4/2/12 at 11:53 p.m. MST revealed Dietary Staff V touched the steam table counter, each resident's laminated food card, and his/her shirt. Dietary Staff V opened each resident's foiled baked potato, removed the potato with his/her contaminated glove, and placed a slice of bread on each resident's place with his/her contaminated gloved hand.

Observations on 4/2/12 between 12:18 p.m. and 12:21 p.m. MST revealed Direct Care Staff G wiped his/her nose four times on his/her pants and failed to clean his/her hands prior to assisting resident #6 with the lunch meal.

Observations on 4/3/12 at 5:12 p.m. MST revealed Dietary Staff T touched the kitchen service counter, a cart handle, and his/her shirt then scooped two serving bowls of tossed lettuce salad into a blender with his/her contaminated gloved hand.

Observations on 4/3/12 at 5:41 p.m. MST

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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F 371	Continued From page 51	F 371		

revealed Dietary Staff U touched the steam table counter, his/her shift, lid handles over the steamed food, the residents' laminated food cards, then placed sliced bread on to each resident's plate with his/her contaminated gloves.

Observations on 4/3/12 at 5:42 p.m. MST revealed Dietary Staff T touched a cart handle, his/her shirt, and served potato chips on to each resident's plates with the contaminated gloves. Dietary Staff T touched the eating surface of each bowl with the thumb of his/her contaminated gloved hand and placed a scoop of yellow pudding in each resident's bowl.

During an interview on 4/4/12 at 4:20 p.m. MST, Dietary Staff H confirmed staff failed to serve food to residents in a sanitary manner by failing to remove soiled gloves, clean hands, and place new gloves before contact with the residents' food.

During an interview on 4/5/12 at 12:50 p.m. MST, Administrative Nursing Staff A confirmed staff failed to serve food to residents in a sanitary manner by failing to clean their hands when soiled prior to assisting residents to eat.

The facility's 3/22/12 "Food Safety and Sanitation" policy instructed staff to wash their hands when they have used their hands in an unsanitary way such as sneezing or handling residents. The policy lacked instructions in relation to use of gloves when handling food.

The facility failed to distribute and serve food in a sanitary manner by failing to clean hands and removed contaminated gloves prior to serving the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 52	F 371		

residents food, including resident #6.

- Observations on 4/2/12 at 10:35 a.m. MST (Mountain Standard Time) revealed a 1/8 full, 1 gallon container of vanilla ice and 1/2 full, 56 oz (ounces) container of strawberry ice cream opened and undated in the activity area freezer. Further observations revealed a 1/8 full, 24 oz container of cottage cheese, a 1/2 full, 6 oz container of whipped cream, and small ziplock bag with approximately 20 cubes of yellow cheese that lacked a date when opened in the activity area refrigerator.

Observations on 4/2/12 at 10:40 a.m. MST revealed an opened and undated bag of sliced rye bread in the kitchen's walk-in freezer.

During an interview on 4/3/12 at 5:30 p.m. MST, Dietary Staff H confirmed staff failed to place a date on items opened in the activity room refrigerator and the kitchen's walk in freezer.

The facility's 3/22/12 "Food Storage" policy instructed staff to place a date on opened items "to indicate that date or day by which a ready-to-eat, potentially hazardous food should be consumed, sold, or discarded will be visible on all high risk food."

The facility failed to store food in a sanitary manner by failing to place an opened date on opened cottage cheese and whipped cream in the activity area refrigerator, on opened vanilla and strawberry ice cream in the activity area freezer, and on an opened bag of rye bread in the kitchen's walk-in freezer.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 53 - Observations on 4/3/12 between 5:04 p.m. and 5:30 p.m. MST revealed Dietary Staff T and U failed to monitor the temperature of the pureed beef stroganoff or tossed salad prior to service. Observations on 4/4/12 at 11:41 a.m. MST revealed a salad bar which included cottage cheese available for residents in the hallway adjacent to the dining area. Review of the facility's March 2012 and April 2012 "Food Temperature Logs" revealed staff failed to monitor pureed or cold items prior to service at each meal. The facility's undated "Dysphagia puree (level 1) diet for casserole" recipe instructed staff to heat to serving temperature of a minimum of 140 degrees Fahrenheit. The facility's undated "Pureed vegetables and salads (tossed salad)" recipe instructed staff to cover and refrigerate below 38 degrees Fahrenheit. During an interview on 4/4/12 at 4:20 p.m. MST, Dietary Staff H confirmed staff failed to monitor the pureed beef stroganoff, pureed tossed salad, and cold items such as cottage cheese prior to serving to the residents. The facility failed to prepare and serve food under sanitary conditions by failing to monitor temperatures of pureed and cold food prior to serving. - Observations on 4/3/12 at 9:15 a.m. MST (Mountain Standard Time) revealed Dietary Staff	F 371		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 54	F 371		

X cleaned 3 of the 8 dining area tables with a rag container with sanitation solution.

During an interview on 4/3/12 at 9:15 a.m. MST, Dietary Staff X reported staff filled the sanitation solution prior to the end of each meal. Dietary Staff X reported staff did not usually monitor the sanitation solution to contain 200 to 400 parts-per-million (ppm) prior to use.

Upon request on 4/3/12 at 9:17 a.m. MST, Dietary Staff X obtained test strips from the facility's kitchen and placed the test strip in the sanitation solution. Observations revealed the test strip failed to change color which indicated by the manufacturer's instructions as "0" ppm on the test strip container.

Observations on 4/3/12 at 9:20 a.m. MST revealed Dietary Staff X took the sanitation container to the facility kitchen. At 9:22 a.m. MST, Dietary Staff X returned to the dining area and placed a test strip in the new sanitation container solution. Observations revealed the test strip changed from yellow to green which indicated 200 ppm on the manufacturer's instructions. Observations between 9:25 a.m. and 9:27 a.m. MST revealed Dietary Staff X cleaned the 3 previously wiped down dining tables with the sanitation solution.

During an interview on 4/3/12 at 5:38 p.m. MST, Dietary Staff H confirmed staff failed to monitor ppm of the sanitation solution prior to use on the dining area tables.

Review of an undated "Sanitation" poster in the kitchen revealed instructions to staff to monitor

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 371	Continued From page 55 ppm after filling the sanitation container with solution prior to each use on dining and kitchen surfaces. The facility failed to serve food under sanitary conditions by failing to sanitize the dining areas tables in between meals.	F 371		
F 372 SS=C	483.35(i)(3) DISPOSE GARBAGE & REFUSE PROPERLY The facility must dispose of garbage and refuse properly. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents and one kitchen. Based on observation, interview, and record review, the facility failed to dispose of garbage and refuse properly (close the lids to the south dumpster 4 out of 4 days which overflowed with refuse 2 of the 4 days). Findings included: - Observations on 4/2/12 at 10:40 a.m. MST (Mountain Standard Time) revealed one of the two dumpster lids on the south side of the facility in the opened position. Observations on 4/3/12 at 10:00 a.m. MST revealed one of the two dumpster lids on the south side of the facility in the opened position. Observations on 4/4/12 at 1:15 p.m. MST revealed refuse in a large, black bag overflowed	F 372		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 56	F 372		

from the upper portion of the opened south dumpster and 4 large, black refuse bags placed approximately 10 feet away from the dumpster at the base of the facility's bricked stairs. Housekeeping/Maintenance/Laundry Staff W walked from a parked vehicle to the 4 large, black bags of refuse and placed each bag in the dumpster but failed to keep the refuse from overflowing.

During an interview on 4/4/12 at 1:19 p.m., Housekeeping/Maintenance/Laundry Staff W reported the kitchen staff regularly used other dumpsters located in another parking lot north of the facility but all other staff used the dumpster on the south side of the facility. Staff W reported a lack of awareness of why the south dumpster remained overflowing with refuse and reported the city usually picked up trash on a timely basis.

During an interview on 4/4/12 at 1:54 p.m. MST, Housekeeping/Maintenance/Laundry Staff S reported a lack of awareness until a few hours prior to the interview that the south dumpster overflowed with refuse and at least one of the two lids remained opened between 4/2/12 to 4/4/12. Housekeeping/Maintenance/Laundry Staff S confirmed the facility failed to dispose of garbage and refuse properly.

Observations on 4/5/12 at 6:30 a.m. MST revealed the south dumpster remained overflowing with refuse and two of the two lids failed to close securely.

The facility lacked a policy regarding the proper handling of refuse related to the dumpsters.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 372	Continued From page 57 The facility failed to dispose of garbage and refuse properly by failing to close the lids to the south dumpster 4 out of 4 days which overflowed with refuse 2 of the 4 days.	F 372		
F 428 SS=E	483.60(c) DRUG REGIMEN REVIEW, REPORT IRREGULAR, ACT ON The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The pharmacist must report any irregularities to the attending physician, and the director of nursing, and these reports must be acted upon. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with 10 residents sampled for unnecessary medication review. Based on observation, interview, and record review, the facility failed to ensure the pharmacist consultant reported irregularities to the physician and the director of nursing regarding Black Box Warnings for 10 of the 10 reviewed residents (#15, 27, 10, 20, 12, 16, 26, 18, 2, and 17). - Resident #15's 2/29/12 physician's orders included diagnoses of acute gastroenteritis, hypokalemia, hypomagnesia, congestive heart failure exacerbation, cerebrovascular accident with left face/arm/leg paralysis, renal insufficiency, restless leg syndrome, atrial	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 58	F 428		

fibrillation, controlled type 2 diabetes mellitus, peripheral vascular disease, lumbar spinal stenosis, hypertension, and degenerative knee arthritis. The 2/29/12 physician's orders included an order for Seroquel (an antipsychotic medication) 25 mg (milligrams) by mouth every evening for agitation.

Resident #15's 1/22/12 Quarterly MDS (Minimum Data Set) Assessment reported moderately impaired cognition, mild depression, and received antipsychotic and antidepressant medications.

Resident #15's 9/28/11 care plan failed to mention the resident received Seroquel or Seroquel's Black Box Warning.

Resident #15's monthly medication regime reviews between September 2011 and March 2012 lacked documentation that the facility failed to mention Seroquel's black box warning in the resident's care plan.

According to blackboxrx.com, Seroquel (Quetiapine) increased mortality in elderly patients with dementia related psychosis greater than placebo.

Observations on 4/3/12 1:14 p.m. MST (Mountain Standard Time) revealed the resident sat in a bedroom recliner with a call light within reach, covered by a blanket, and his/her legs remained elevated on the recliner foot rest.

During an interview on 4/5/12 at 10:52 a.m. MST, Consultant Staff E reported an awareness of the need to alert staff of black box warnings and confirmed the facility failed to mention black box

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 59	F 428		

warnings in the residents' care plans.

The facility failed to ensure the pharmacist consultant reported irregularities to the physician and the director of nursing related to Seroquel's Black Box Warning for resident #15.

- Resident #27's 3/9/12 physician's orders included diagnoses of congestive heart failure, atrial fibrillation, hypothyroidism, hypercholesterolemia, hypopotassemia, dementia without behavioral disturbances, depressive disorder, glaucoma, hypertension, coronary arteriosclerosis, osteoarthrosis of pelvic and thigh region, and a pacemaker. The 3/9/12 physician's orders renewed orders for Amiodorone (a heart medication) 200 mg (milligrams) by mouth daily and Acetaminophen (a pain and fever medication) 500 mg by mouth at breakfast and 650 mg by mouth every four hours as needed for pain.

Resident #27's 3/23/12 Annual MDS I(Minimum Data Set) Assessment reported severely impaired cognition and the resident did not receive a special category of medications.

Resident #27's 4/3/12 lacked mention of black box warnings for Amiodorone or Acetaminophen.

Resident #27's monthly medication regime reviews between September 2011 and March 2012 lacked documentation that the facility failed to mention black box warnings for Amiodorone or Acetaminophen in the residents care plan.

According to blackboxrx.com, Amiodorone (Cordarone) posed "major management

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 60	F 428		

problems that could be life-threatening in a population at risk of sudden death, so that every effort should be made to utilize alternative agents first and liver injury is common with Cordarone, but is usually mild and evidenced only by abnormal liver enzymes. Overt liver disease can occur, however, and has been fatal in a few cases."

According to blackboxrx.com, Acetaminophen held the "potential for severe liver injury and a warning highlighting the potential for allergic reactions (e.g., swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) [were] being added to the label of all prescription drug products that contain acetaminophen."

Observations on 4/4/12 11:05 a.m. MST (Mountain Standard Time) revealed resident #27 ambulated independently in his/her room with a steady gait.

During an interview on 4/5/12 at 10:52 a.m. MST, Consultant Staff E reported an awareness of the need to alert staff of black box warnings and confirmed the facility failed to mention black box warnings in the residents' care plans.

The facility failed to ensure the pharmacist consultant reported irregularities to the physician and the director of nursing related to black box warnings for Amiodorone and Acetaminophen for resident #27.

- Resident #10's physicians order sheet listed the following diagnoses of dominant side hemiplegia, hypertension, depressive disorder, aphasia, dysphagia, obesity, anxiety state, convulsions and

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 61	F 428		

hypothyroidism and constipation. The physician order sheet also included an order for Fentanyl patch 50 mcg (micrograms) to be changed every 72 hours for pain.

Resident #10's 2/4/12 Quarterly MDS Assessment indicated the resident had a moderately impaired cognitive status and received an antidepressant medication during the assessment period.

Resident #10's 2/2/12 Care Plan failed to mention any monitoring for side effects or adverse reactions from the use of medications which had black box warnings.

According to blackboxrx.com, the following medication contained black box warnings: Fentanyl: "This product contains a high concentration of a potent Schedule 2 opioid agonist, fentanyl. Schedule 2 opioid substances have the highest potential for abuse and associated risk of fatal overdose due to respiratory depression."

Review of resident #10's monthly Medication Regimen Review for the past year revealed a lack of information related to black box warnings.

On 4/4/12 at 6:35 a.m. (MST) mountain standard time, direct care staff L and R assisted resident #10 with morning cares. The resident had no signs of depression or inappropriate behaviors during cares.

An interview with licensed staff C on 4/4/12 at 8:30 a.m. MST confirmed that monitoring for medications with black box warnings had not

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 62	F 428		

been included in the residents nursing care plans.

During an interview on 4/5/12 at 10:55 a.m. MST, consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with BBWs, but had not incorporated the information into the nursing care plans.

The facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and the director of nursing as related to resident #10's use of Fentanyl, which had a black box warning.

- Resident #20's 2/8/12 physician order sheet listed diagnoses of depression, nonpsychotic mental disorder, Parkinson's disease, hypertension, hypoactive sexual desire disorder, coronary atherosclerosis, congestive heart failure, and osteoarthrosis. The physician's order sheet also had an order for Seroquel 25 mg (milligrams) at hour of sleep.

Resident #20's 12/26/11 quarterly MDS (Minimum Data Set) assessment revealed the resident had intact cognition, no inappropriate behaviors, and received antidepressant medications.

The resident's 12/21/11 nursing care plan had information related to the resident's diagnosis of depression, however, the care plan lacked any information related to the resident's use of Seroquel which had a BBW (Black Box Warning).

According to blackboxrx.com, Seroquel contained this BBW, "Elderly patients with dementia related

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 63	F 428		

psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo" and "close observation for suicidal thinking or unusual changes in behavior."

During an observation on 4/4/12 at 11:30 a.m. MST (Mountain Standard Time), resident #20 sat at the dining room table after eating a meal. The resident had no inappropriate behaviors during the meal.

An interview on 4/4/12 at 2:34pm MST with licensed staff C revealed resident #20's nursing care plan did not include information related to medications that had BBWs.

During an interview on 4/5/12 at 10:55 a.m. MST, consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with BBWs, but had not incorporated the information into the nursing care plans.

The facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and the director of nursing as related to resident #20's use of Seroquel which had a BBW.

- Resident #12's physicians order sheet listed the following diagnoses of hypopotaassemia, depression, Parkinson's disease, macular degeneration, hypertension, coronary atherosclerosis, dyspepsia, vertigo, chronic airway obstruction, and osteoarthritis. The physicians order sheet also included an order for Toprol 25 mg (milligrams) by mouth twice a day.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 64 Resident #12's 7/21/11 Annual MDS (Minimum Data Set) Assessment and the 10/20/11 Quarterly MDS indicated severely impaired cognition. Resident #12's Care Plan failed to mention any monitoring for side effects or adverse reactions from the use of medications which had black box warnings. According to blackboxrx.com, the following medication contained a black box warning: Toprol: "Beta-blocker therapy should not be withdrawn abruptly (particularly in patients with coronary artery disease) but gradually tapered over 1 to 2 weeks to avoid acute tachycardia, hypertension, and/or ischemia." Review of resident #12's monthly Medication Regimen Review for the past year revealed a lack of information related to black box warnings. On 4/4/12 at 8:15 a.m. MST, resident #12 ambulated with steady gait to the bathroom while assisted by direct care staff L and R. An interview with licensed staff C on 4/4/12 at 8:30 a.m. MST confirmed that monitoring for medications with black box warnings had not been included in the residents' nursing care plans. During an interview on 4/5/12 at 10:55 a.m. MST consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 65 BBWs, but had not incorporated the information into the nursing care plans. The facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and the director of nursing as related to resident #12's use of Toprol which had a black box warning. - Resident #16's 3/8/12 physician order sheet included diagnoses of anxiety state, hypothyroidism, hypopotassemia, dementia, depressive disorder, macular degeneration, hypertension, congestive heart failure, dyspepsia, cerebral atherosclerosis, osteoarthosis, and insomnia. The physician order sheet included an order for Seroquel 25 mg (milligrams) at hour of sleep. Resident #16's 1/29/12 quarterly MDS (minimum data set) assessment revealed the resident had intact cognition and received antipsychotic and antidepressant medications. Resident #16's current nursing care plan included information related to anxiety and depression, however, lacked any information regarding potential side effects and adverse reactions related to the use of Seroquel which had a BBW (Black Box Warning). According to blackboxrx.com, Seroquel contained this BBW, "Elderly patients with dementia related psychosis treated with atypical antipsychotic drugs are at an increased risk of death compared to placebo" and "close observation for suicidal thinking or unusual changes in behavior."	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 66	F 428		

During an observation on 4/3/12 at 3:00 p.m. MST (Mountain Standard Time), resident #16 ambulated independently in the hallway with a steady gait and did not exhibit any signs of depression or inappropriate behaviors.

An interview on 4/4/12 at 2:34 p.m. MST with licensed staff C revealed resident #16's nursing care plan did not include information related to medications that had BBWs.

During an interview on 4/4/12 at 3:30 p.m. MST, administrative nurse A confirmed the facility currently did not include information regarding BBWs in the residents' nursing care plans.

During an interview on 4/5/12 at 10:55 a.m. MST, consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with BBWs, but had not incorporated the information into the nursing care plans.

The facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and the director of nursing as related to resident #16's use of Seroquel which had a BBW.
- The signed Physician Orders dated 2/1/2012 for resident #2 included diagnoses of subendocardial infarction, congestive heart failure, anemia, sleep arousal disorder, depressive disorder, other extrapyramidal diseases and abnormal movement disorders, other specified hemiplegia and hemiparesis affecting unspecified side, tear film insufficiency, essential hypertension, coronary atherosclerosis

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 67	F 428		

of unspecified type of vessel, transient cerebral ischemia, late effects of cerebrovascular disease, constipation, hemorrhage of gastrointestinal tract, pain in joint involving multiple sites, general muscle weakness, osteoporosis, dizziness and giddiness, insomnia, weight loss, diarrhea, urinary incontinence, history of diseases of circulatory system not elsewhere classified.

Resident #2's signed Physician Orders dated 2/1/2012 included an order for Tylenol 500 milligrams.

The 2/24/2012 Quarterly MDS (minimum data set) assessment for resident #2 identified him/her with severely impaired cognition, no reported behaviors, no reported falls, and reported mild pain received pain medication.

Resident #2's 4/3/2012 nursing care plan lacked direction to staff related to the use of Tylenol which had a BBW (Black Box Warning).

According to blackboxrx.com, Acetaminophen (Tylenol) had the potential for causing severe liver injury and had the potential for causing allergic reactions such as: swelling of the face, mouth, and throat, difficulty breathing, itching or a rash.

Record review of pharmacy consultant reviews revealed resident #2 had no recommendations or irregularities for January 2012, December, November, October, September, or August 2011.
During an observation on 4/3/2012 at 4:50 p.m. MST, resident #2 stood in his/her room, in front of his/her wheel chair, alert, sorting papers, without signs of pain or distress noted.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 68	F 428		

During an interview on 4/4/2012 at 5:15 p.m. MST (Mountain Standard Time), administrative nursing staff A verified that resident #2's care plan lacked information related to the Black Box Warning for Tylenol.

During an interview on 4/5/2012 at 10:52 a.m. MST, consultant staff E verified resident #2 took a medication that contained a Black Box Warning and staff needed to know that information as it related to resident #2's Tylenol.

The facility failed to ensure resident #2 did not receive unnecessary drugs (drugs used without adequate monitoring) when the facility failed to monitor for potential side effects and adverse reactions as related to BBWs for Tylenol.

- The signed Physician Orders dated 3/1/2012 for resident #17 included diagnoses of adult failure to thrive, dehydration, hypothyroidism, vitamin B deficiency, vitamin D deficiency, hypopotassemia, atypical depressive disorder, tobacco use disorder, Alzheimer's disease, Parkinson's disease, essential hypertension, cerebral aneurysm nonruptured, chronic airway obstruction, dyspepsia, constipation, neurogenic bladder, osteoarthrosis, insomnia, edema, history of venous thrombosis and embolism, long term use of anticoagulants.

Resident #2's signed Physician Orders dated 2/1/2012 included orders for Fluoxetine 20 milligrams, Tylenol 500 milligrams, Remeron 15milligrams, and Coumadin 2 milligrams.

The 12/30/2011 Quarterly MDS (minimum data set) assessment for resident #17 identified the

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 69	F 428		

resident as cognitively intact with no behaviors noted, urine incontinence, occasional pain and received pain medication and an antidepressant.

Resident #17's 4/3/2012 nursing care plan lacked direction to staff related to the use of Fluoxetine, Tylenol, Remeron, and Coumadin which all had BBWs (Black Box Warnings).

According to blackboxrx.com, the following medications contained BBWs:
o Fluoxetine: patients started on Fluoxetine had the potential for clinical worsening, suicidality, or unusual changes in behavior.
o Tylenol: Acetaminophen (Tylenol) had the potential for causing severe liver injury and had the potential for causing allergic reactions such as: swelling of the face, mouth, and throat, difficulty breathing, itching or a rash.
o Remeron: patients started on Remeron (Mirtazapine), had the potential for clinical worsening, suicidality, or unusual changes in behavior.
o Coumadin: Coumadin (Warfarin) had the potential to cause major or fatal bleeding at the beginning of therapy and with higher doses resulting in a higher INR (International Normalized Ratio).

Record review of pharmacy consultant reviews revealed resident #17 had no recommendations or irregularities for February, January 2012, December, or September. October 2011 review had a risk/benefit statement from the doctor to support the continued use of the Remeron.

During an observation on 4/4/2012 at 8:50 a.m. MST (Mountain Standard Time), direct care staff

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 70 K and L assisted resident #17 out of bed and to the bathroom. Resident #17 had no signs or symptoms of pain or distress noted during transfer and ambulation. Resident remained calm and cooperative with staff members. During an interview on 4/4/2012 at 5:15 p.m. MST (Mountain Standard Time), administrative nursing staff A verified that resident #17's care plan lacked information related to Black Box Warning for Fluoxetine, Tylenol, Remeron (Mirtazapine), and Coumadin (Warfarin). During an interview on 4/5/2012 at 10:52 a.m. MST, consultant staff E verified resident #17 took medications that contained a Black Box Warning and staff needed to know that information as it related to resident #17's Fluoxetine, Tylenol, Remeron, and Coumadin. The facility failed to ensure resident #17 did not receive unnecessary drugs (drugs used without adequate monitoring) when the pharmacist failed to identify or report medication or medication combinations with significant potential for adverse consequences or medication interactions related to BBWs for Fluoxetine, Tylenol, Remeron, and Coumadin. - Resident #26's 3/7/12 physicians order sheet listed diagnosis of adult failure to thrive, anxiety disorder, vitamin D deficiency, coronary atherosclerosis of artery bypass graft, urinary tract infection, osteoarthrosis, epistaxis, urinary incontinence and allergies. Physician order sheet also listed orders for Tylenol, Lasix, Atenolol, and Coumadin.	F 428		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 71	F 428		

The Quarterly (MDS) Minimal Data Set on 2/21/12 indicated resident #26 had severely impaired cognitive cognition and received antidepressant therapy.

Review of resident #26's care plan revealed the care plan lacked direction to staff regarding potential side effects and adverse reaction of medication with BBW (black box warning).

Review of resident #26's monthly Medication Regimen review revealed lack of information related to black box warnings for the past year.

According to www.blackboxrx.com the following medication contained black box warnings:
Acetaminophen: " In addition, a Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (e.g., swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) are being added to the label of all prescription drug products that contain acetaminophen".
Lasix: "This agent is a potent diuretic which, if given in excessive amounts, may lead to profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule must be adjusted to the individual patients needs (see DOSAGE AND ADMINISTRATION)."
Atenolol: "Beta-blocker therapy should not be withdrawn abruptly but gradually tapered to avoid acute tachycardia, hypertension, and/or ischemia".
Coumadin: " May cause major or fatal bleeding."
On 4/4/12 at 7:50 a.m. MST (mountain standard

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 72	F 428		

time) direct care staff K and M assisted resident # 26 with activities of daily living. The resident remained calm and cooperative with cares.

During an interview on 4/4/12 at 12:30 p.m. MST administrative nurse B confirmed resident # 26's nursing care plan lacked information regarding potential side effects and adverse reactions of black box medications.

During an interview on 4/5/12 at 10:55 a.m. MST, consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with BBWs, but had not incorporated the information into the nursing care plans.

The facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and the director of nursing as related to resident #26's use of Acetaminaphen, Lasix, Atenolol, and Coumadin which had black box warnings.

- Resident #18's 3/9/12 physicians order sheet listed diagnosis of chronic ischemic heart disease, chronic pulmonary heart disease, acquired hypothyroidism, vitamin D deficiency iron deficiency anemias, dysthymic disorder, other extrapyramidal diseases and abnormal movement disorders, congestive heart failure, esophagitis, urinary frequency, long-term use of anticoagulants, insomnia, calculus of kidney, and osteoarthrosis.

Resident #18's 3/9/12 physician order sheet also listed orders for Tylenol, Lasix, Cuprimine,

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 73	F 428		

Atenolol, and Coumadin.

The Admission MDS (Minimal Data Set) on 11/23/11 and the Quarterly MDS on 1/3/12 assessments for resident #18 indicated the resident had moderately impaired cognition, no behaviors and received antidepressants.

Residents #18's care plan on 4/3/12 lacked direction to staff regarding potential side effects and adverse reaction related to Acetaminophen, Lasix, Cuprimine, Atenolol and Coumadin, which had BBWs (Black Box Warning).

According to www.blackboxrx.com the following medication contained black box warnings:
Acetaminophen: "In addition, a Boxed Warning highlighting the potential for severe liver injury and a Warning highlighting the potential for allergic reactions (e.g., swelling of the face, mouth, and throat, difficulty breathing, itching, or rash) are being added to the label of all prescription drug products that contain acetaminophen."
Lasix: "This agent is a potent diuretic which, if given in excessive amounts, may lead to profound diuresis with water and electrolyte depletion. Therefore, careful medical supervision is required, and dose and dose schedule must be adjusted to the individual patients needs (see DOSAGE AND ADMINISTRATION)."
Cuprimine: " Physicians planning to use penicillamine should thoroughly familiarize themselves with its toxicity, special dosage considerations, and therapeutic benefits. penicillamine should never be used casually. Each patient should remain constantly under the close supervision of the physician. Patients

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 428	Continued From page 74 should be warned to report promptly any symptoms suggesting toxicity ". Atenolol: "Beta-blocker therapy should not be withdrawn abruptly but gradually tapered to avoid acute tachycardia, hypertension, and/or ischemia." Coumadin: " May cause major or fatal bleeding." Review of resident #18's monthly Medication Regimen Review revealed a lack of information related to black box warnings from November 2011 through March 2012. Observations of resident #18 on 4/3/12 at 4:15 p.m. MST (mountain standard time) revealed an alert, cooperative, calm, and oriented resident. During an interview on 4/4/12 at 12:30 p.m. MST, licensed staff B confirmed that resident # 18's care plan lacked information related to potential side effects and adverse reactions to medications with BBWs. During an interview on 4/5/12 at 10:55 a.m. MST, consultant E reported recently becoming aware of the need for black box warnings on care plans. He/she reported the medication administration record currently identified medications with BBWs, but had not incorporated the information into the nursing care plans. The facility failed to ensure the consultant pharmacist reported any irregularities to the attending physician and the director of nursing as related to resident #18's use of Acetaminaphen, Lasix, Cuprimine, Atenolol, and Coumadin which had black box warnings.	F 428		
F 431	483.60(b), (d), (e) DRUG RECORDS,	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431 SS=E	Continued From page 75 LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. This REQUIREMENT is not met as evidenced by:	F 431		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 76	F 431		

The facility had a census of 25 residents and stored injectable medications in refrigerators located in the East hall and South hall charting rooms.

Based on observation, interview, and record review the facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. (Multi-dose vial of influenza vaccine for stock use, multi-dose vials of vitamin B12 and Humalog insulin for resident #3, and Novolog insulin for resident #15)

Findings included:

- An observation on 4/2/2012 at 10:55 a.m. MST (Mountain Standard Time) revealed the east hall staff charting room medication refrigerator had an opened multi-dose vial of influenza vaccine with no date when opened.

An observation on 4/2/2012 at 11:05 a.m. MST revealed the south hall staff charting room medication refrigerator had an opened multi-dose vial of B12, an opened vial of Humalog insulin with no dates when opened. Both medications belonged to resident #3. The south hall medication refrigerator also had an opened vial of Novolog insulin with no date when opened for resident #15.

During an interview on 4/3/2012 at 3:50 p.m. MST, administrative nursing staff A verified staff should date all opened vials of medication and discard them when they have expired.

The 8/11/2008 medication policy and procedure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 431	Continued From page 77 indicated all medications, once opened, should have a date. The policy lacked specific information for when to discard opened injectable medications. According to www.humalog.com <http://www.humalog.com>, the official Humalog insulin site, once opened, discard Humalog vials after 28 days. According to www.novolog.com <http://www.novolog.com>, the official Novolog insulin site, once opened, discard Novolog vials after 28 days. The facility failed to label drugs and biologicals used in the facility in accordance with currently accepted professional principles. (Multi-dose vial of influenza vaccine for stock use, multi-dose vials of vitamin B12 and Humalog insulin for resident #3, and Novolog insulin for resident #15)	F 431		
F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an Infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 78 actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents and the sample contained 12 residents. Based on observation, interview, and record review, the facility failed to provide a sanitary environment and prevent the development and transmission of disease and infection. The facility staff failed to wash their hands after each direct resident contact and demonstrate proper hand hygiene with use of gloves as indicated by accepted professional practices. The facility also failed to clean and disinfect glucometers used by multiple residents. (2 non-sampled residents)	F 441		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 79	F 441		

Findings included:

- During an observation on 4/4/2012 at 9:40 a.m. MST (Mountain Standard Time), licensed nursing staff B failed to sanitize the glucometer after he/she performed blood sugar checks.

During an interview on 4/4/2012 at 9:45 a.m. MST, licensed nursing staff B verified he/she failed to sanitize the glucometer after use. Licensed nursing staff B verified the facility had 2 residents that had blood sugar checks 4 times daily

Although requested, the facility lacked a policy and procedure for sanitizing the glucometer between residents.

During an observation on 4/4/2012 at 8:45 a.m. MST, direct care staff L failed to wash or sanitize his/her hands upon removing gloves after he/she performed pericare on a resident.

During an observation on 4/4/2012 at 8:50 a.m. MST, direct care staff K failed to wear gloves to carry the trash sack to the dirty utility room.

During an interview on 4/4/2012 at 9:05 a.m. MST, direct care staff L verified he/she failed to usually wash or sanitize his/her hands after removing his/her gloves.

During an observation on 4/4/2012 at 9:15 a.m. MST, direct care staff N failed to wash or sanitize his/her hands upon removing gloves after he/she performed pericare on a resident.

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 441	Continued From page 80 During an observation on 4/4/2012 at 9:15 a.m. MST, direct care staff P failed to wash or sanitize his/her hands upon removing gloves after he/she handled soiled linens. Direct care staff P failed to wear gloves to transport the sacks of trash and soiled linen to the dirty utility room. During an interview on 4/4/2012 at 9:30 a.m. MST, direct care staff N verified he/she failed to wash or sanitize his/her hands between different resident care tasks. During an interview on 4/4/2012 at 9:30 a.m. MST, direct care staff P verified he/she failed to wear gloves to transport items to the dirty utility room. During an interview on 4/4/2012 at 5:15 p.m. MST, administrative nursing staff A verified that staff received hand washing education in March of 2012. Administrative nursing staff also verified that staff should wash their hands after wearing gloves and staff should wear gloves when handling trash or soiled linens. The facility failed to provide a sanitary environment and prevent the development and transmission of disease and infection. The facility staff failed to wash their hands after each direct resident contact and demonstrate proper hand hygiene with use of gloves as indicated by accepted professional practices. The facility also failed to clean and disinfect glucometers used by multiple residents. (2 non-sampled residents)	F 441		
F 456 SS=F	483.70(c)(2) ESSENTIAL EQUIPMENT, SAFE OPERATING CONDITION The facility must maintain all essential	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 81 mechanical, electrical, and patient care equipment in safe operating condition. This REQUIREMENT is not met as evidenced by: The facility reported a census of 25 residents with one kitchen and one laundry room. Based on observation, interview, and record review, the facility failed to maintain essential mechanical equipment (2 industrial laundry washers and 1 dishwasher) in safe operating condition by failing to keep the equipment free of lime buildup. Findings included: - Observations on 4/2/12 at 10:43 a.m. MST (Mountain Standard Time) revealed lime buildup on each edge of the dishwasher's front and back doors. Further observations revealed lime buildup on the edges of the rinse basin, temperature gauge, and opening where cleaning solution connected to the dishwasher. During an interview on 4/3/12 at 5:41 p.m. MST, Dietary Staff H confirmed staff failed to remove the lime buildup from the dishwasher and reported a lack of awareness of how to remove the lime. Although requested, the facility failed to provide documentation of removal of lime buildup from the dishwasher on the cleaning schedule. During an interview on 4/4/12 at 2:21 p.m. MST, Housekeeping/Maintenance/Laundry Staff S	F 456		

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E071	A. BUILDING _____ B. WING _____	04/11/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
GREELEY COUNTY HOSPITAL LTCU	506 THIRD PO BOX 338 TRIBUNE, KS 67879

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F 456	Continued From page 82 reported kitchen staff as responsible to remove lime buildup from the dishwasher. Observations on 4/4/12 at 11:18 a.m. MST revealed lime buildup below each door and down the front panel of two of the two industrial laundry washers. Further observations revealed approximately a half inch buildup of mineral deposits around the top opening where cleaning solution connected to each washer. During an interview on 4/4/12 at 2:21 p.m. MST, Housekeeping/Maintenance/Laundry Staff S reported staff removed the lime buildup with a de-liming cleanser on a monthly basis but failed to remove the lime since January 2012. Although requested, the facility failed to provide documentation of the monthly laundry cleaning schedule. The facility failed to maintain essential mechanical equipment, which included 2 industrial laundry washers and 1 dishwasher, in safe operating condition by failing to keep the equipment free of lime buildup.	F 456		